1. Introduction

a. Lt. Governor: Good afternoon everybody and welcome to the third meeting of 2022 for The Maryland Commission to Study Mental and Behavioral Health. I want to start with just providing a brief update on some legislative wins in the mental and behavioral health space here in Maryland. First, The Interstate Counseling Compact. It was officially enacte and ten states have signed up for it and several other states are still considering it. We're hoping they'll get it through in their next legislative session. Unfortunately, Virginia didn't take it up in their session that recently ended. I know Delaware is looking into it, and West Virginia is one of the ten states signed on. We will have to work on Virginia and Pennsylvania.. As I mentioned in this recommendation here, the compact, once its regulations are established, will allow professional licensed counselors and therapists to give reciprocity so they don't have to go through the new permitting or licensing process to be able to see patients in participating states. We were one of the first states to participate. I think we were second to Georgia coming on board with legislation, so we're very proud that we were able to step up. We're hoping it'll address some of our issues in terms of workforce. It does also open the door for telehealth services, as the person that may be licensed in another state will be now able to work with a patient that's here in Maryland. That can help with some of the telehealth services that we had in place during the state of emergency. Also, during the legislative session, we were able to get through the statewide Targeted Overdose Prevention Act or "Stop Act", and the bill did pass the general assembly. It provides greater flexibility in use of naloxone and encourages getting naloxone to people early in the high-risk groups, such as those coming out of our criminal justice system, those who recently were in treatment for non-fatal overdose in the emergency rooms, as well as people coming out of treatment facilities, homeless service providers, and others who can make it available to individuals who data has shown are at a higher risk of overdose. Lastly, with regard to funding and the 2023 budget, we were able to put an additional $293 million dollars for substance disorder services, more than $230 million for mental health for individuals that are without insurance, and more than $11 million dollars to support the sixth year of work of the Opioid Operational Command Center. We're working to make sure that we reduce the dependency and overdose fatalities in the state.

2. Attendance & Minute Approval

a. Attendance
   i. Present: Senator Adelaide Eckardt, Delegate Karen Lewis Young, Tricia Roddy, Lieutenant Colonel Roland Butler, Deputy Assistant Secretary Tiffany Rexrode, Director Robin Rickard, Mary Gable, Dr. Bhaskara Tripuraneni. Kimberly Watts, Barbara Allen, Deputy Secretary Christain Miele, Patricia Miedusiewski, Richard Abbott, Dr. Lisa Burgess, Associate Commissioner David Cooney, Secretary Dennis Schrader, Serina Eckwood, Carrie Cho
   ii. Absent: Director Lynda Bonieskie, Senator Katie Fry Hester, Delegate Arian Kelly

b. Minute Approval
   i. Lt. Governor: Minutes will be sent out at a later date.

3. Subcommittee Reports

a. Crisis Services
   i. Lisa Burgess: Thank you Lt. Governor. I'll start with system developments. Through a SAMSA grant, BHA has allocated funding to five jurisdictions to expand the availability of peer recovery specialists to support individuals experiencing a crisis who are utilizing a walk-in crisis stabilization center. Those five jurisdictions are Frederick, Harford, Howard, St Mary's, and Worcester. Funding has also been awarded to Calvert county for the expansion of their walk-in crisis stabilization center. The Behavioral Health Administration continues to work closely with the Medicaid Administration and stakeholders to develop the funding structure for mobile crisis response teams and walk-in crisis stabilization centers. Based on the Center for Medicare and Medicaid Services guidelines, regulations and billing codes are being developed. Draft regulations are currently being drawn up. BHA continues to collaborate with stakeholders, including, but not limited to, the Maryland Hospital Association. This is towards financial sustainability through emergency room diversion. The Governor included $5 million dollars in his Fiscal Year 23 Budget to support the 988 Call Center Workforce. In addition, BHA has awarded two grants from SAMSA to expand the workforce development for crisis call centers. Close to two million dollars for two years was awarded to support recruitment and retention of the call central workforce. $500,000 was awarded to develop training modules for 988 call centers in Maryland. The training modules

are designed to focus on specialized communities. Next, I'll go into the data dashboard and assessment. Maryland has selected the Crisis Assessment Tool (CAT) as the standardized screening tool to be used with children and adults in crisis. BHA is working closely with the University of Maryland Innovations Institute to lead training on the implementation of the CAT with early adopter jurisdictions including Calvert, Harford, and mid shore counties. The CAT will be used by mobile crisis teams and walk-in crisis stabilization centers around the state.

ii. I'll move into the report on the young adults, children, and adolescents. BHA, in partnership with the local behavioral health authorities, has launched the quality learning collaborative for mobile response stabilization services across the state. This effort includes statewide technical assistance and quality improvement meetings, as well as county level readiness assessment meetings and follow-up technical assistance support. This model uses mobile crisis response teams for initial intervention and provides intensive follow-up specifically designed for children, youth, and families.Through the work of both the leadership team of the crisis stakeholders committee and the best practices subcommittee, a Maryland model for a comprehensive crisis system has been developed. This model has incorporated key elements of the census Crisis Now Model, including someone to call (call centers and hotlines), someone to respond (mobile crisis teams), and somewhere to go (crisis standardization centers). In partnership with the Office of Facilities Management and Development, BHA is working on developing and implementing regional comprehensive crisis centers. These regional crisis centers will serve as a coordinating entity to support the key components of the comprehensive crisis system model. This will also allow regional, local adaptability to meet the specific needs of each community. The western region has been selected as the first location where a regional crisis hub will be developed. Lastly BHA is contracting with mobile crisis providers to develop mobile crisis and response teams. to service children, families, and adults. BHA continues to host crisis system listening sessions among residents and stakeholders in the community. And with that Lt. Governor I end my report except for any questions.

b. Youth and Families

i. Christian Miele: Our subcommittee held its last meeting on April 11th, and we facilitated two presentations at this meeting. The first such presentation was from Paul Ballard. Mr. Ballard is an Assistant Attorney General with the Department of Health, and he also serves as counsel for the health decisions policy group, as well as the quality of care to end of life. In that capacity, I've worked with him and asked him to make a presentation on advanced health care directives, and he provided some really valuable information to the subcommittee, with a particular focus on the opportunity that Marylanders have to memorialize their wishes when it comes to making mental health decisions related to their treatment. Generally, an advanced directive can outline mental health services which may be provided to an individual, in case of their subsequent incapacity to make healthcare decisions for themselves. Basically, the way it kicks in is if you have a temporary or permanent incapacity (which would be something that is declared by two physicians). The advanced directive would then become effective and binding. The document also gives Marylanders the ability to designate a healthcare agent to make decisions about the mental health services that they're to receive and their subsequent incapacity. If they're incapacitated, that's when their designated health care agent steps in and has legal authority. This document also governs for the individual entering into this advanced directive with preferred mental health professionals that they'd like to work with and preferred programs and facilities. It also allows individuals to identify preferred medications, give instructions about notifying third parties, as well as authorizing the release of mental health information to those third parties. The subcommittee learned that while anyone can prepare their own form of advanced directive, for mental health services you don't need an attorney to do so. It only requires two witnesses. It doesn't have to be notarized like a power of attorney would, but, for everyone's edification, the Department of Health has prepared a template form that a person may choose to use and the department's directive is available online through the behavioral health administration. After my presentation, I'll be posting a link to this template in the chat box so that anyone interested can take a look at that and share that as well with friends, family, and colleagues.

ii. The second presentation at the last subcommittee meeting was from Karen Duffy, and Ms. Duffy's the chief program officer with the Maryland Coalition of Families. She discussed with us the services her organization provides in connection with its new family peer support program. The Maryland Coalition of Families is a statewide nonprofit that's based in Colombia and Howard county. They offer family peer support services at no cost to families, caregivers, and/or loved ones of individuals experiencing behavioral health challenges. The mission of the family peer support is to connect with families through shared experience, because the program staff there know firsthand what it's like to care for someone with a behavioral health issue, and they draw on that experience to offer emotional support, share knowledge, build skills, and connect Maryland families with resources and opportunities in their own localized communities. The benefits of this particular program, “The Family Peer Support Program,” includes fostering a greater sense of collaboration and empowering people to take action towards improving their own situations, including developing a greater willingness to work with a member of a treatment team. Additionally, peer support helps families feel more comfortable and capable navigating systems, understand terminology, and acquire the skills to feel confident in their journey toward treatment, as well as to help make improvements in the practice of self-care while reducing feelings of isolation and avoiding the practice of internalized blame. The Maryland Coalition for Families focuses predominantly on transitional age populations, but they made it clear they will work with people of any age. However, they mostly concentrate on working with adults who have loved ones with substance use issues in all corners of the state and also support families experiencing gambling problems. I also want to mention, since youth is obviously a major component of the work of our subcommittee, that the Maryland Coalition of Families has a program called, “Taking Flight,” which is the organization's young adult group for people aged 18 to 26, and they work specifically to reduce stigma by providing education around mental health issues. They offer informal peer support and support groups, promote young adult leadership, and they also participate in state committees and legislative events to bring youth voices to the policy making process. If anyone is in need of help from the coalition (and I'll also put this in the chat box) they can

call 410-730-8267. They can email the organization directly at referral at mdcoalition.org, or you can visit the website at mdcoalition.org\referrals to complete their referral form. In summary, all the services of the offer are completely free and confidential families will be paired with an FPSS with similar experience. Services are not time limited and support will be tailored to the specific needs of the family seeking consultation. In addition to that, we provided legislative updates, many of which were covered at the beginning of this commission meeting. Our next subcommittee meeting for youth and families has been scheduled for June 13th at 1pm. That is our report and I'll turn it back over to you Lieutenant Governor.

c. Finance and Funding:
    i. Tricia Roddy: Good afternoon everyone. As everyone knows, the Finance Committee is co-chaired by medicaid and MIA, so I will give the Medicaid update and then turn it over to David Cooney for the MIA portion. The finance subcommittee met last week and our next meeting is scheduled for July 11th from noon to 1. The first item we discussed with the finance committee was that we gave an update on the system of care integration and optimization work group. Just to remind folks, work group brings together our managed care organizations with the behavioral health community and works on initiatives to help improve the system of care. Obviously, one of the main topics that this group is interested in is our Behavioral Health Administrative Service Organization. We are working on the next request for proposals for the next vendor. We gave a presentation to the work group members and allowed them to provide comments. They have until the end of the month to provide comments. We covered this topic over two meetings with the work group. One meeting was focused specifically just on care coordination. Both groups wanted to make sure that there were enough requirements in the RFP to hold both entities accountable, both the MCO as well as the ASO. During those conversations, it became apparent that there's concerns about the current flow of information that's happening. As everyone knows here, substance use data can't be shared without specific permissions. Because of the low return rate, data right now isn't being submitted between the MCOs and the ASO, so we're going to be focusing on that topic in terms of data sharing at the next

meeting for July 11th, and we'll keep you all posted on those conversations.

ii. Secondly, I've mentioned to this group in past meetings about the additional money that's coming to the Medicaid program through the American Rescue Plan Reinvestment. Again, Medicaid is able to get a 10% additional federal match on certain home and community based services. That additional match went from April 1st 2021 through March 31st of 2022. There is a catch. The CMS didn't just give us this additional 10% match to balance our budget. The requirement is to take this additional money coming and reinvest it back into the program. We talked with the group about it on the behavioral health side. 75% of the reinvestment dollars went into a provider rate increase that went into effect November 1st of 2021. That rate increase was a 5.4 increase. Secondly, we took the remaining 25% of the reinvestment dollars and submitted a plan to CMS to spend those dollars on implementing a new provider type in the medicaid program. Specifically, that provider type is a peer certified peer recovery specialist. I'm happy to report that CMS approved that spending plan just last week. Now, that's just one approval. We have to get the official documents in place to actually reimburse for the service, and we have to implement the program. It will probably take a good six to eight months to implement, but we've got the first approval to begin those conversations, so that's really exciting.

iii. Lastly, I know Dr. Burgess talked about some of the funding, but we also talked about what specifically we're covering under the Medicaid program. Not only are we going to be covering the certified peer recovery specialists, but of course the governor’s budget funded our mobile crisis, so we will be implementing a new provider type for mobile crisis services. In the last supplemental budget that was recently signed during the legislative session, there is money for medicaid to cover 23-hour crisis beds. There was $35 million dollars in general funds given to the medicaid program, so that's three big new service expansions that are going to be happening within the Medicaid program over the next year. With that, I'll turn it over to David and then of course I'll be here to answer any questions.

iv. David Cooney: Thank you Tricia. As we've been talking about for the past year, the big initiative we were working toward in the private health insurance market was a review of the new required

reports from insurance carriers to demonstrate that insurers are not applying non-quantitative treatment limitations or NQTLs to behavioral health benefits in a manner that conflicts with mental health parity laws. Those NQTI reports were finally due on March 1st of this year, and we received reports from most of the carriers by the due date, but there were three carriers that missed the deadline. There were also additional data supplements that were due on April 1st, and those were received by the deadline from most of the carriers. Unfortunately for both the NQTL analysis reports and the data supplements, there were many errors and oversights in the manner in which the reports were filed, and that necessitated amended filings before we could begin our formal review. So, at this point, we have received almost all the amended files and the in-depth reviews have begun. All together, we received reports for 193 different health benefit plans. Each report is required to include detailed analysis and justification for 14 different categories of possible NQTLs. These are very large and complex comprehensive reports. Because reviewing these reports is a very complex and also new process for everyone involved, staff are still being trained on the precise things to look for. We do, however, have some initial observations from a cursory view of reports, and what we've seen so far suggests that most reports do not even include sufficient information and analysis to be considered complete according to the regulations we adopted and the instructions that we put on our website. For this reason, the MIA anticipates issuing orders for both late and incomplete reports in the coming months, while, at the same time, our staff will continue to go through the detailed review. Unfortunately, as we expected, despite the really clear language that was in the statute and the specific direction that we provided in our regulations, due to the complexity of the analysis here and the lack of experience by carriers in filing these reports, there's going to need to be a significant amount of follow-up correspondence between our agency and the carriers in order to really get all the information we need to complete the review and ultimately determine whether there are parity violations. This situation is not unique to Maryland. We've consistently heard from other state and federal regulators. The carriers have just been unprepared to provide sufficient analyses from UTLs to document compliance. This is even though the Federal Parity Act has expressed the required

carriers to provide these reports since February of 2021. Now, I should note that this doesn't necessarily mean the benefits under these policies are not being provided at parity. At a minimum, however, it does mean that it appears the carriers have failed to adequately demonstrate parity for many of the NQTLs and their initial filings. This is really disappointing, because it is going to delay the entire review process, and this is why we are planning, as I mentioned, to issue those initial orders based on the late and complete reports just to give the carriers additional incentive to get us the information we need as soon as possible. I can now turn it back over to the Lieutenant Governor unless there's questions for either me or Tricia.

4. **Special Presentation -** *Lower Shore Clinic Assertive Community Treatment Program*
   a. See Attached
   b. Dimitri Cavathas

5. **Discussion**
   a. Lt. Governor: I'll ask the first question then. You mentioned that it's really a set up for those individuals who have not been successful in traditional treatment or other treatment methods. How do you find your clients? Do you go up to a person who's on the street who you know is showing signs of mental instability? How do you find them?
   b. Dimitri Cavathas: It's a great question. What the health system will tell you is that they know who those persons are because they're in and out of the ER. They are on the street a lot of times, so homeless outreach teams know this as well. Also, one of the great strengths of the Maryland system is it allows us to engage people initially and be reimbursed for that. So you might have a person living on the street with a significant persistent mental illness, but we are allowed to actually go out and engage them upon referral. Another strength of the Maryland system is that the barrier to referral is extremely low, so even a self deferral is allowed. There's a lot of different ways that this occurs. A lot of times, the ERs and the inpatient units will contact us. We'll have homeless average teams, jails contact us, as well as the public behavioral health or service agencies and health systems conatct us, which will see a person running up significant health costs in inpatient care in particular.
   c. Lt. Governor: I guess it does make sense that emergency rooms as well as the local jails might be good referrals, where they know that they have a person there that violated the law but has severe mental illness.

d. Dimitri Cavathas: Yes, usually the persons that we're getting are in that 5% of the population of medicaid that cause 50% of the budget, or the 1% of the medicaid population that cost 25% of the budget. So, they're usually on the radar and these ACT teams are specifically designed to engage and deal with these kinds of issues.
e. Barbara Allen: I have some questions and comments. First of all, when I look, Dimitri, at various things, one of the things we talk about in recovery is recovery capital, and that's the set of tools that someone has. A simple example is housing. If you don't have a place to stay (you're couch surfing, you're in a tent, you're in your car) that's not a stable environment. There's a lot of things in here, like grocery shopping assistance, helping people do things that many of us just take for granted, even as simple as purchasing and taking care of clothing. I appreciate so much that they help with identifying job skills, and we do have some jurisdictions which have programs through the Department of Labor which are very helpful in the coordination. Generally, an individual in these cases often doesn't understand that coordination between services. When you talked about act teams being sustainable, you said once a team reaches seven to eighty members it's sustainable. I must've missed who those seven to eighty groups are.
f. Dimitri Cavathas: Thank you. When a team builds up a census of consumers of around seven to eighty clients (and again it depends on the organization that's running the team) it is officially breaking even at that point. When I say sustainable, in other words, it's not losing money anymore, and it will be sustainable for the future. a team of 100 clients with a fully staffed team is sustainable for as long as Medicaid exists.
g. Barbara Allen: Is that because of the funding and the reimbursements for those services?
h. Dimitri Cavathas: Yes, correct. The Medicaid rate is established; it's a good rate actually in Maryland. I want to give credit to Maryland for having a rate that supports an ACT team properly. That program will be sustainable, so you really only need startup money. Usually, an ACT team needs, in this day and age with inflation, around $500,000 to $600,000. Once it gets a certain size then it moves on. I also want to talk about the peer approach as well, and I heard earlier about Medicaid getting the approval for the peer specialist. ACT teams have had peer specialists in their teams for decades, and in particular our peer recovery specialists focus on wellness recovery action plans, with each client to talk about this capital that he described. Barbara, I really appreciate you bringing it up in particular.
i. Lt. Governor: Any more questions for Dimitri?

j. Dr. Bhaskara Tripuraneni: I have a question for Dimitri. Thank you Dimitri; it was a great presentation. Could you tell us how long typically a client stays within your system?
k. Dimitri Cavathas: That's a great question. We actually have to track that for our evidence-based fidelity, and the average day is around three years.
l. Senator Eckardt: Dimitri, good work. It's good to hear such positive results, but I did have one question. Have you done any data analysis or financial analysis of how much you've saved in either emergency room visits or other episodes of decompensation? Having to go back into the hospital, do you have any sense on that?
m. Dimitri Cavathas: We have, and it's close to a million dollars from pre-post. Now, what I can say to you is we're really looking into what this is, why this is, and honestly to validate it, and I'm very excited to tell you that we have obtained funding to hire a full-time research assistant professor from the University of Maryland School of Social Work to be here for the next three years to study what we're doing. I like to just use the crisp data because it looks really good, and I think I can confidently say we're definitely saving money. I'm not as confident to say how much even though crisp data says that. And it does break down where the money is saved; a lot of that is surgical for example, but I want to come back at some point to this fine group in a couple of years and give actual research that proves what we're doing.
n. Senator Eckardt: Thank you. What's your turn over in your staff? To me, it's the relationships and it's the stability of the relationships over time, so have you been able to kind of capture what constitutes keeping a team together?
o. Dimitri Cavathas: Yes, but it's very difficult at the same time. We actually do have to measure turnovers, but, as part of our fidelity review, we get reviewed by the state of Maryland. It's usually one or every two years, so we actually have to track this and we're in the 30 percentile range, which is not ideal. The ideal is around 15%, so we're really double the ideal rate. Part of it had to do with the fact that this is a very non-traditional program. I went to the school of social work. I love my school; I actually was an adjunct there for 11 years, but we don't really prepare people for this kind of work. It's really geared more for clinics and other traditional services. If you get someone to take the job, they're in this very non-traditional approach, and it's sometimes just not a good match and that's what happens.
p. Senator Eckardt: It's helpful so we know what we need to do going forward. It’s something we want to capture and preserve and then prepare people to be able to handle it. Thank you.

q. Patricia Miedusiewski: Dimitri, great presentation. I have to say thank you for being here, but, when you were talking about the reimbursement, meeting the fidelity measures does result in the reimbursement, is that correct?
r. Dimitri Cavathas: Correct. This is one part I don't like. There is a connection of the fidelity rate to a higher rate and this creates a significant amount of stress on the organizations around this.
s. Lt.Governor: I'm not familiar with fidelity rate could you define that for me?
t. Dimitri Cavathas: There's a standard mobile team rate in the public behavioral health system, and if you meet a score in this research fidelity scale, then you get a higher rate as a result of that. These 26 teams, that'll soon be 27 teams, are constantly being reviewed every year or every two years, and we're holding on to make sure that we pass to a certain level to get the higher rate. It does create a dynamic that can be very intense at times, and that is the one thing I wish we could change, but I don't expect the commission to do that. All you have a lot of other things going on, but that is something that is very difficult.
u. Patricia Miedusiewski: But the data does assure us of the quality. So, the higher they meet the fidelity measure, the more quality the whole system gets (for the patient and everybody). That would be good data to see where the team actually sits most of the time, and then that also tells us because we talk about insurances now (what you get for your money those kind of things and outcome measures and all this), but doing this act team is so organized, and it really gives you a picture. Plus, as you said, and everybody knows I feel this way, it really does give you that integration between these two disorders, which we know that the majority of people have.
v. Dimitri Cavathas: Yes, it's so important. Where our clinic is licensed is an integrated clinic, and obviously the act teams are also a very integrated model. It really is critical to be able to merge all these disciplines in particular around addiction, behavioral health, and somatic care too. It's so important.
w. Lt. Governor: Last, is a statement that has to do with the saving, Dimitri. In one of the areas, of course, if you're reducing the amount of people going into the hospital, or even just going into the emergency room, there's a savings in terms of the expense, but also just the opportunity. I know it gets to be tricky to determine what actual savings, but one of the areas we've heard a lot about, particularly from the hospitals, is if you have a diversion away from going into the emergency rooms there's a savings there.
x. Dimitri Cavathas: Yes, thank you. Not only did the ER visits go down, but the real savings occurs in inpatient days. That's where, if you look at the crisp data in particular, you'll see a big shift in inpatient cost versus the ER cost.
y. Tricia Roddy: One comment I will make is that, just in general, CMS is pushing us to have payment based on outcomes. We are aligning even and changing the

way that we're paying primary care. It's not mandatory, but it's an option that CMMI is pushing us to build. That's the movement and where the federal government wants to see us go.

z. Dimitri Cavathas: Actually, thank you for that, because we are part of the Maryland Primary Care Program, and it has been a godsend to us. We think it's a wonderful program; it really helped us through the pandemic in particular. Dr. Haft and all that group over there have been just wonderful, and I want to specifically thank you for that as well. It's been great.

aa. Secretary Dennis Schrader: I had a question. As you were briefing, which I found fascinating, I would ask, do you see an integration of this or a coordination? We have put a major emphasis on building crisis centers over the next 10 years. In fact the governor just got the first million dollars into this last budget. we're going to start a process in western Maryland. We've identified four regions, but that doesn't mean there might not be more. How do you see the coordination of what you're doing with ACTt with the crisis center game plan?

bb. Dimitri Cavathas: Thank you so much, and that is a great question. I worked one night a week for eight years on a mobile crisis team in Howard County out of the grassroots building, so I'm very familiar with how mobile crisis teams work. I see a real beautiful integration and marriage between the centers for mobile crisis teams, assertive community treatment teams, and residential crisis beds, and I see those four programs dancing together to serve clients in a real seamless fashion. They complement each other so well. You have the mobile crisis team doing the real short-term intervention, the immediate short-term intervention, maybe the crisis center following up with that. then maybe putting a client into a crisis bed, with an assertive community treatment team coming along to further the treatment afterwards. I think this is such a huge opportunity for that.

cc. Secretary Dennis Schrader: Do you think there's a possibility we can reduce the number of forensics beds through diversion with this with the combination of this program and crisis? Because that's the other thing we're looking at, and, again, we're peering through a crystal ball that's 10 years to 20 years from now, but could this lead to a reduction in the number of people who are put in jail because law enforcement or judiciary community gets them first?

dd. Dimitri Cavathas: I know I had experience in Montgomery County pretrial services, as an example, so I think that there's a web of things that we can do to prevent people from entering the criminal system. I do think, when you beef up the crisis system, it will prevent future criminal interventions that would occur with our clients. The forensic bed issue is very complicated because of the courts and the way they operate. Mental health courts can be very helpful too at times, so I do think that you could definitely prevent people from entering the system itself. I think there's definitely opportunity there.

ee. Secretary Dennis Schrader: Thank you, appreciate it. Well, I'll be following up our staff offline on this. Very interesting, thank you for the presentation.
ff. Dimitri Cavathas: Thank you so much. I really appreciate that.
gg. Lt. Governor: Dimitri, thank you very much. This is very informative.

6. Public Testimony

a. Lt.Governor: At this point, we can move on to public comment,
b. Katie Rouse: Good afternoon Lt. Governor and commission members. Thank you so much for the opportunity to join you all today and to speak. I'm Katie Rouse, representing Honor of Maryland, and for 30 years we've brought the consumer and pure voice into matters of behavioral health system planning policy and improvement efforts. Like some other organizations providing testimony today, we wanted to take this opportunity to share some very serious concerns regarding the proposed transfer of the Spring Grove Hospital Center Campus from the Department of Health to UMBC. I do want to say very clearly that we do not begrudge UMBC any opportunity to build on its success. They are really a shining star in the University of Maryland system, and I would say that even if I weren't a proud alumna. Our concern about this proposed transfer is a lack of clarity, consistency, and stakeholder input regarding the plans for spring grove, because it's not only going to impact the nearly 400 people who reside in beds there, but it's also very demonstrative about the state's commitment to sustaining accessible, equitable, and responsive public behavioral health services. In that facilities master plan, Springer was rated the worst in infrastructure out of all of the inpatient facilities, but the planning process for transitioning services and residents was pushed forward a full decade into phase three, which was to start in 2032, and that process of organizing those transfers is anticipated to be challenging, because so many of the people who are there have complex medical, legal, and behavioral health considerations. There are many folks who are subject to court order in terms of their future. Please know we are very much in favor of the state moving people out of hospitals, especially out of places with significant historical stigma and inadequate amenities like those at Spring Grove. This proposed transfer to UMBC seems to make the process vulnerable to acceleration or pressure by interests that are totally outside of the behavioral health system, since UMBC is slated to get full use of the campus as soon as all the buildings are vacated. If this campus is already so difficult and expensive to manage, then what is gained by adding another layer of bureaucracy, by having another partner outside the department of health. If the state's goal is to more quickly move people out of Spring Grove's aging buildings and into better care, then why was the planning process deferred for a decade, and what has changed now? How is the system preparing community providers to serve folks who do have more

complex medical or legal needs, by expanding programs that can help people, like the act teams that Dimitri just spoke about or programs that work with folks who are currently institutionalized and to receive better care in the community, like Baltimore City's Outpatient Civil Commitment Pilot Program. I just want to say that the future of Spring Grove Hospital is not just a business decision. It's really tremendously symbolic to the people who received care or something less than care at that institution to people who visited loved ones there or saw their loved ones remain there for several years or even sometimes until their deaths, because there was a lack of appropriate step-down services in the community. To move forward with such a major decision about this this long-standing institution without a meaningful process to inform or engage or partner with peers, families, advocates, and providers is just not something that a trauma-informed and recovery-oriented and system-centered person-centered system would do. We want to use this time to just respectfully ask the commission to please hold our system to a higher standard and to thank you for hearing us.

c. Lt. Governor: Thank you. Lori Doyle?
d. Lori Doyle: Thank you, Lt. Governor and members of the commission. Lori Doyle here on behalf of the Community Behavioral Health Association of Maryland. We have 105 organizational members who provide community-based mental health and substance use disorder treatment and support services. We, as Miss Rouse is, are very concerned about the last minute appearance of this transfer on the board of public works agenda. This seemingly precipitous action involved little to no input from stakeholders and drastically speeds up the process by 10 years of the timeline and the master facilities plan for addressing Spring Grove. We have a statute on our books. It's been on there for quite some time (for decades now) called the Community Services Trust Fund, and it was passed by the general assembly specifically for circumstances like this. The sale lease transfer of a facility and the creation of this fund was to allow the money to follow people into the community, so there would be adequate services for them when they leave a state hospital. This transfer will basically preclude that community services trust fund from getting a dime. The land housing Spring Grove is very valuable property, and we know that because this has been a subject of conversation for many years. I've been around a long time, not only UMBC, but many developers have wanted to buy this land, and we're willing to spend a lot of money on it. So, what do we do now? We have providers who are out here, who have been serving people, taking folks out of places like Spring Grove, but we're faced now with housing challenges and workforce challenges that are unprecedented. We need an infusion into the community, and we need to be more creative in how we provide our services. You just heard the act team.s There's a lot of innovation happening in the community. We need the opportunity to sit

down with you all as partners and talk about the various options and alternatives before we move forward with a plan like this. We ask that you postpone this decision and bring stakeholders together in a thoughtful, meaningful, and planful process to really try to make decisions on what's best for the folks at Spring Grove. After all, they are in the state's care, and we should be doing the best we can by them. Thank you.

e. Lt. Governor: Thank you very much. Dan Martin?
f. Dan Martin: Mr. Lieutenant Governor, thank you very much. Commission members, a pleasure to be here. I am going to echo a lot of what my colleagues said. They probably said it much more eloquently than I will, but I am here to talk on behalf of MBHA about the proposed transfer of Spring Grove Hospital Center. I know this is a bit outside of the commission's control because BPW will be making the decision. Since the behavioral health commission felt really compelled to bring it to your attention, I just want to say up front that we are not here to derail this in any way. We think UMBC is a great institution and this may be a very good thing for our state, but we do have some concerns. Mainly, we don't know what we don't know. The remarks on the BPW agenda item for this transfer indicate that this action with the department of health facilitates the master plan that this commission was briefed on a couple of months ago. We were briefed on it too and appreciate that briefing. According to the plan, for the transition of services at Spring Grove is part of phase three. This is slated to take place in 2032 for 10 years, starting in 2032. Beyond that, recommendations in the plan related to Spring Grove are slim at best. There is no mention of transferring Spring Grove to UMBC and our concern here is the same as my colleagues'. There has not been an open process or discussion about the plans. The first time we even heard about the master plan was last fall when it was released and we were not notified of or included in any planning process leading up to that release. We agree with the department of health that the facility is substandard and is in need of attention. We are eager to hear about the department's plans to improve care and the environment for patients and staff. They are both in the future and in the short term, but these plans are not discussed in the facility's master plan and they should be shared for public consideration. This is a big decision asking for tomorrow at BPW. I know this isn't directly in your purview, but you are the behavioral health commission. With that being said, I felt compelled to share these thoughts with you and thanks for the opportunity.
g. Lt. Governor: Secretary, would you like to comment on any of the remarks that were made?
h. Secretary Schrader: Yes, thank you Lt. Governor Rutherford. I am glad for the feedback and input. I want to say a couple things that I hope alleviate anyone's concerns. Spring Grove will remain open and MDH will provide services for it to

be so. It takes about five to 10 years to develop a plan that is this comprehensive. The master plan lays out the framework and we are now going to shift into program development. This process will begin to bring a lot more people into it. In the master plan, we did mention Spring Grove and its action route. The master plan itself took five years to develop. When I was first here in 2017, there was very little money in the capital budget of the health department. The first thing we needed to do was have a master pland begin to put money in. DBM has worked with us on this. The $1M we received was specifically enabled by the master plan. We are going to continue to use and maintain these facilities. There are two five year renewal options in case we do not get everything done that we need to. This is about a 20 year process. We have had some preliminary conversation with the community. They are concerned about traffic in the area with Wade Street closed. We have been working with them on that. There was a review conducted on the valuation of that property. There will be a very robust process as described. This is just the beginning of a decade long process. I will stop there. Thank you Lt. Governor Rutherford for allowing me to share a few words.

i. Lt. Governor: I saw a question asking what is the Board of Public Works. The Board of Public Works takes place in the State House biweekly, on Wednesdays at 10am. It is also live streamed on the Board of Public Works website. And with that, I will pass it over to Evelyn Burton.

j. Evelyn Burton: The only thing I was going to mention about the hospital transfer is that it seems curcial to decide where these patients are going to go if a new hospital is going to replace it. Maybe some of the land could be retained to continue to host and care for those patients. I mainly want to thank the Lt. Governor and the commission for listening to the testimony of many families and individuals regarding the current mental health danger standard. The standard has led to homelessness, incarceration, and suicide. The many families that have testified concerning the harmful effects of this standard have also touched on the lack of interpretation of disability or psychiatric deterioration. A better defined danger standard could prevent these tragedies before they occur. Many of these families talk about these tragedies ask why did we bother going through this. The commission has not even discussed the report released by the health department to modify the standard and has made no recommendation of their own. The stakeholder group and the department did not hear any of the public testimonies. My question is when will the commission discuss the report and make their own recommendations. Lt. Governor, you mentioned in the Jnauary meeting that the commission can do this. My question is, when can it be scheduled? Thank you very much.

k. Lt. Governor: Thank you very much. I think we can plan on scheduling that soon. There will probably be a recommendation after the one more report we have to make.
l. Evelyn Burton: Thank you very much.
m. Lt. Governor: Okay everyone. Our next meeting will be July 12th and will also be virtual. Thanks to those who testified, Dimitri for your informative presentation, as well as the public members who spoke.